SAMPLE NOTIFICATION FORM
Insert school name, address here

Date:_____

Dear_____ :

Your child(ren) _____
_____
_____
_____
_____

have been:

___ Approved for free meals because

( ) your household income was within the eligibility limits
( ) one or more of your children are enrolled in FIP or Food Assistance
( ) your child(ren) are homeless, migrant or runaway
( ) your child is enrolled in Head Start

____ Approved for reduced price meals

____ Denied because

( ) your income over the allowable amount
( ) your application was incomplete

If you do not agree with the decision, you may discuss it with the school. If you wish to review the decision further, you have a right to a fair hearing. This can be done by calling or writing the following official:

NAME _____

ADDRESS _____

PHONE_____

You may reapply for benefits at any time during the school year. If you are not eligible now but have a decrease in household income, become unemployed, or have an increase in family size, fill out an application at that time.

You may be eligible for Food Assistance. Food Assistance, also known as Food Stamps, is a program to help buy food for good health. If you want information or you want to apply, call 1-877-347-5678. Go to www.yesfood.iowa.gov to apply online.

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___ Approved for free meals because one or more of your children were directly certified automatically.

Federal law allows us to receive information about your family's participation in FIP or Food Assistance programs to determine free meal eligibility. No other information about your family has been shared.

Your child(ren) listed on the reverse side of this form will get free meal benefits automatically. There is nothing you need to do. If you do **NOT** want your child(ren) to receive these automatic free meal benefits, you must tell us. Fill in the information below and return it this notice to the school within ten calendar days of the date on this letter.

I DO NOT want my child(ren) to receive free meal benefits.

Child's Name: _____ School:_____

Child's Name: _____ School:_____

Child's Name: _____ School:_____

Parent/Guardian Name (Printed)_____

Signature_____ Date_____

hawk-i /Medicaid Information Form

Read this information. Sign below and return it to the school **if you decide you do not want** your name released to ***hawk-i*** or Medicaid.

If your children do not have health insurance, you will be interested to know that many families getting free and reduced price meals can also get free or low-cost health insurance for their children.

The law now requires schools to share your free and reduced price meal eligibility information with Medicaid and ***hawk-i***, the State's medical insurance program for children. Specifically, we will give them your child's name and your name and address. Medicaid and ***hawk-i*** can only use the information to identify children who may be eligible for free or low-cost health insurance and then to contact you. They are not allowed to use the information from your free and reduced meal application for any other purpose.

You are not required to allow us to share information from your children's free and reduced price meal application with Medicaid or the ***hawk-i*** program. It will not affect your children's eligibility for free and reduced price meals. If you do **NOT** want your information shared with Medicaid or ***hawk-i***, you must tell us by completing the information below and returning this letter to the school district within 10 days of the date on the letter of notification of free meal benefits. If you want further information, you may call ***hawk-i*** at 1-800-257-8563.

I DO NOT want school/home sponsor/child care or Head Start center officials to share information from my free and reduced price meal application with Medicaid or ***hawk-i***. Also, if you are already receiving Medicaid or ***hawk-i***, please sign below. This will avoid another contact.

Child's Name: _____ School/Child Care/Head Start Center:_____

Child's Name: _____ School/Child Care/Head Start Center:_____

Child's Name: _____ School/Child Care/Head Start Center:_____

Parent/Guardian Name (Printed)_____Signature_____Date_____

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly. In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write to *USDA, Director, Office of Civil*

TURN PAGE OVER

Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410, or call (800) 795-3272 (voice) or (202) 720-6382 (TTY). USDA is an equal opportunity provider and employer.